STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

# REPORT OF

# TARGET MARKET CONDUCT EXAMINATION

# OF

# KING COUNTY MEDICAL BLUE SHIELD

# AT

# P. O. BOX 21267

# SEATTLE, WASHINGTON 98111

# AS OF

# NOVEMBER 4, 1996

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The Honorable Deborah Senn
Washington Insurance Commissioner
Olympia, Washington 98504

Dear Commissioner Senn:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.145, I have examined the corporate affairs and market conduct of:

King County Medical Blue Shield

P. O. Box 21267
Seattle, Washington 98111

hereafter referred to as "the Company" or "KCMBS" or "KCM". The following report is respectfully submitted.

## Scope of Examination

The examination was performed in compliance with the provisions of Washington insurance laws and regulations. The market conduct review followed the rules and procedures promulgated by the Office of the Insurance Commissioner (OIC) and the National Association of Insurance Commissioners (NAIC). The examination covered the period of January 1, 1996 through November 4, 1996. The scope of this examination was limited to time service for claim payments on those claims from the Clallam County Physician Service (CCPS) groups, and review of the provider contracts in effect for the Clallam County Physician Service area providers.

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## CLAIM ADMINISTRATION

During 1996, several changes were made in the way that CCPS claims are paid.

01/01/96 State Employees (PEBB) claims were no longer paid by CCPS. They are now sent to KCMBS’s government programs unit located in KCMBS's Thurston County office. All KCMBS PEBB claims are paid from this office.

Basic Health Plan (BHP) and Healthy Options (HO) claims were sent to KCMBS's Seattle office for adjudication, along with all other KCMBS affiliate and subsidiary BHP and HO claims.

03/15/96 Ceased processing claims on the existing system in order to get ready to move to the KCMBS system.

04/01/96 Began processing claims for CCPS contracts and statewide account claims on the KCMBS system. Some training of processors on the new system had been done, but most claims had to be shipped off to other KCMBS offices for adjudication while training continued.

present CCPS processors are not completely trained on the new system. At this time, claims are received in the CCPS office, logged in and then shipped to the appropriate processing office. The CCPS staff is not fully trained on handling system edits (errors) or in adjustment processing. Because of this, the staff handles what they can of the CCPS business, and fill in on work from other offices to help with backlog. The management at the CCPS office did not have a training completion date.

A random sample of 200 claims adjudicated from January 1, 1996 through November 4, 1996 were selected for review during this examination. The claims were checked to determine the type of claim, the date it was received by CCPS and the paid date. For the period examined, the overall time service average was 19.24 days from receipt by CCPS to payment. There were 24 claims that took from 30 to 60 days to complete. Twelve claims took more than 60 days for payment. 82% of the sample were paid in less than 30 days.

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A breakdown of time service by type of claim follows:

| Claim Type | # Claims | Average # Days Received to Paid |
|---|---|---|
| Physician | 111 | 16.57 |
| Pharmacy | 40 | 14.38 |
| Other * | 32 | 24.25 |
| Hospital | 17 | 38.65 |

* Other includes chiropractic, lab, mental health, dental, vision, and nurse practitioner claims.

Company time service reports for May and June 1996 were available during the examination. Per these reports, May time service was calculated at 82.3% of claims processing in less than 30 days. For June, 83.1% were processed in under 30 days.

Detailed information was gathered on the 12 claims exceeding the 60 day payment time frame.

They breakdown by type is:

| | |
|---|---|
| Physician | 5 |
| Chiropractic | 3 |
| Hospital | 2 |
| Other | 1 |

In reviewing the claim records on the 12 claims, it appears that in all cases, the reason for the delay in processing was that the Clallam office staff was not trained on the system to handle the claim. Therefore, the claim was either held until they were trained to do that work, or sent to another office for payment. It could be held in either the CCPS office or the KCM office that was assigned to help with the claim backlog.

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**PROVIDER CONTRACT REVIEW**

In September 1995, Clallam County Physician Service merged with King County Medical Blue Shield. At that time, all providers continued under their CCPS provider contracts. Beginning in October of 1995, providers were offered the KCMBS contract. Until August of 1996, the Company used both contract forms. In August, the Clallam contracts were canceled. At that time, only the hospital anesthesiology group and the radiology group had not signed new contracts. As of October, the radiology group and the majority of the anesthesiologists had not signed a KCMBS participating provider contract. The radiology group had applied for participating status and were in the KCMBS provider credentialing process. Both groups were paid at the maximum fee schedule rate.

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The KCMBS Provider Contract was reviewed to determine the type of payment arrangement KCMBS has with providers. Two of the generic provider contracts were reviewed: the Participating Provider Agreement and the Participating Physician's Agreement. Section V.B, second paragraph is both contracts addresses payment of claims:

> "The COMPANY shall make reasonable efforts to pay Claims promptly, and within thirty days of receipt of a clean claim. A clean claim is defined

by the COMPANY as a claim which in the COMPANY's opinion does not require special handling or further review such as a Claim held for medical review determination, coordination of benefits, other party liability considerations, subrogation, eligibility or Claims submitted using non-approved forms and/or procedure codes and any other similar handling. The PROVIDER shall not have any claim against the COMPANY for failure to pay Claims within any specific period of time. Those Claims requiring further review will be paid as promptly as possible and depending on the outcome of the additional review required. the PROVIDER will maintain a written record of all treatment for which payment is requested. The COMPANY may deny claims in those cases where there is inadequate documentation of the services rendered, in which case the PROVIDER shall not bill the patient."

In reviewing actual claims, it was not possible to determine clean claims from those requiring investigation. However, in the review of the 12 claims taking more than 60 days to process, only four of the 12 claims appear to have required investigation. The May and June time service statistics furnished by the Company indicate that they fall short of paying all clean cases within 30 days of receipt.

| | % complete within 30 days (Pay Provider) | % complete within 30 days (Pay Member) | % complete within 30 days (Combined) |
|---|---|---|---|
| May 1996 | 82.2% | 91.4% | 85.3% |
| June 1996 | 85.0% | 94.1% | 87.8% |

## SUMMARY OF EXAMINATION FINDINGS

In summary, it appears that for a part of 1996 claim payment was lagging. The reason for the slow time service appears to be the change to the KCMBS computer system. It also appears that KCMBS did not manage the backlog of claims during the training period. Claims were held for up to 60 days in order to use them as training material, creating a backlog of claims and slow processing time. As of the examination date, the Clallam staff is still not completely trained and some types of claims are still sent out of the office for adjudication.

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**Instructions**

There are no instructions to be issued on this report.

**Recommendations**

1. It is recommended that priority be given to complete training of the Clallam office staff so that all claims can be processed at the local site. This will eliminate the need to send claims off site to be adjudicated and should improve time service.

2. The Company needs to improve efforts to pay clean claims within 30 days. In connection with this requirement, it is recommended that until the local staff is trained to handle all phases of computer usage, that claims outside of their expertise be sent immediately to other offices for adjudication and not held in the local offices until the processors are trained. This appears to be the reason for slow time service. Moving claims through the system in a timely manner will alleviate the slow claims turnaround time.

3. The transition plan of KCMBS was not successful in terms of training personnel or issuing timely payments to participating providers. In this era of consolidation of health carriers, it is recommended that this large carrier develop a better transition operational plan. Such planning would lessen the impact of any future mergers or acquisitions on consumers and providers.

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**ACKNOWLEDGMENT**

Acknowledgment is hereby made of the cooperation extended to the examiner by the employees of King County Medical Blue Shield during the course of this examination, especially those employees in the Clallam County Physician office.

Respectfully Submitted,

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Leslie A. Krier, AIE, FLMI

Examiner-in-Charge

State of Washington

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**AFFIDAVIT - MARKET CONDUCT EXAMINER**

State of Washington)

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County of King )

Leslie A. Krier, being duly sworn, deposes and says that the foregoing report subscribed by her is true to the best of her knowledge and belief.

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Leslie A. Krier, AIE, FLMI

Market Conduct Examiner

Subscribed and sworn to before me this 17th day of April, 1997.

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Notary Public for the State of

Washington, Residing at

Seattle.

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**AFFIDAVIT - CHIEF MARKET CONDUCT EXAMINER**

I certify that I have reviewed the report of the Target Market Conduct Examination of King County Medical Blue Shield as of November 4, 1996.

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Pamela Martin

Chief Market Conduct Examiner